MSS Post Pregnancy Risk Factor Clarification Table

Risk Criteria	Clarification notes
Maternal Race - Client (woman) identifiers herself as: • American Indian, Alaskan Native, non-Spanish speaking indigenous women from the **Americas** i.e. Mam or Kanjobal speaking women from Guatemala and Mixtecas from Oaxaca, Mexico • Black or African American	• The intent of this risk factor is to identify women of African American and American Indian descent. Birth certificate outcome data may include Alaskan Native or Non-Spanish speaking indigenous women from the Americas. The risk factor has been expanded to include these groups. • At the current time due to budgetary conditions and mandates from the WA State Legislature to focus on certain groups of high risk women, this risk factor does not apply to women who are Spanish speaking only, or to women who are monolingual in other languages. • This risk factor is focused on the race of the mother only.
Prenatal Care- No prenatal care established in pregnancy	• See Post Pregnancy RF matrix
Food Insecurity: Runs out of food before the end of the month or cuts down on the amount eaten to feed others.	• Refer to prenatal clarification notes • Families stretching food costs, for example: watering down formula; using mother's WIC voucher to feed others, impacting health of breastfeeding mother or infant.
Pre-pregnancy BMI: IOM = Institute of Medicine • Pre-pregnancy BMI **25.0 to 29.9** • Pre-pregnancy BMI greater than or equal to **(≥) 30.0** and pregnancy weight gain **within** IOM guidelines • Pre-pregnancy BMI greater than or equal to **(≥) 30.0** and weight gain **outside of the** IOM guidelines.	• See prenatal clarification notes • Determine if pregnancy weight gain was within the guidelines: **Singleton Pregnancy:** <18.5 BMI 28-40 lbs 18.5 to 24.9 BMI 25-35 lbs 25.0 -29.9 BMI 15-25 lbs ≥30.0 BMI 11-20 lbs *Women with the highest pre-pregnancy BMI (34+) should be at lower level of recommended weight gain **Multiple Pregnancy:** <18.5 BMI ~40 lbs plus 18.5 to 24.9 BMI 37 to 54 lbs 25.0 -29.9 BMI 31 to 50 lbs ≥30.0 BMI 25 to 42 lbs • Clients are sensitive about weight in most circumstances so being cautious of the words you use and providing positive messages will be important. • Clients who start out overweight and obese and then become pregnant are at higher risk of weight retention post pregnancy that can lead to a lifetime of obesity and chronic disease.

	• These clients are at high risk of infection, poor healing, depression and breastfeeding complications. • Most clients have a decline in appetite post pregnancy and tend to be happy about this because they want to lose weight but it can cause problems with healing and coping with motherhood effectively without basic nutrition. Most moms need support in recognizing that they need to eat but how to balance weight loss with motherhood and taking care of themselves. • If the client is concerned about weight loss this is a good time to support the client in options for eating healthy to support her goal and referral to WIC RD if she is unable to have ongoing support from the MSS RD (limited units).
Inter-pregnancy interval: Current pregnancy conception less than (<)9 months from the end of last pregnancy	• See prenatal clarification table RF matrix. • Good health teaching moment – inter-conception care. Even if she delivered full term healthy infant, to have another shorten birth interval between this and next pregnancy, puts her and that fetus at risk.
Medical Risk Factors: **Fetal death**: Fetal death in this pregnancy- fetus greater than 20 weeks gestation and died in utero or born dead. **Diabetes:** • History gestational diabetes with last pregnancy • Pre-existing Diabetes- type 1 or 2 • Curent gestational diabètes **Hypertension:** • History of gestational hypertension • Chronic Hypertension diagnosed prior to pregnancy or before 20 weeks gestation • Gestational Hypertension with current pregnancy. • Post partum hypertension	**Medical Risk Factors**- this can be self report but you must probe to ensure it was diagnosed by health care provider and not just client diagnosed. • **Fetal death-** Both parents may be experiencing grief. Mother and father should be supported with family planning, coping and genetic testing if indicated and desired. Infant death in the MSS period (after birth to 2 months postpartum): Infant death as a risk factor during this period would fall under the category of Preterm/ LBW – infant was born premature/LBW and didn't survive; or Infant health problems – health issues which resulted in death. Currently Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID) are considered health issues of unknown cause. • **Type 1 and 2 Diabetes and Chronic Hypertension:** Clients with chronic disease will need to learn how to balance chronic disease management (diet, exercise, stress management and medications) with motherhood. These moms are also at high risk for depression and post partum healing. • **Gestational Diabetes & Gestational Hypertension:** MSS providers can support the medical care provider by providing health education and follow up. Generally these conditions resolve after delivery but may not. Providers should educate clients on long term risk of developing chronic disease, and provide health messages regarding a healthy lifestyle. • **Post partum hypertension:** is a leading cause of maternal mortality (although low in WA). Postpartum blood pressure (BP) may increase three to six days after birth when most women have been discharged home. A significant rise in BP may be dangerous (e.g., lead to stroke). MSS providers can further support

Medical Risk Cont'd **Multiples:** Delivered more than one baby	medical care provider in the post partum period by: 1) communicating with medical provider regarding protocol for when to refer woman back to provider for changes in hypertensive status or symptoms; reinforcing medical providers health messages with client, supporting woman in following through with post partum visits and any medical treatment. • **Multiples:** Multiple births can result in increased physical and psychological stress for mother/ both parents due to medical complications, c-section delivery, and infants born preterm or with medical problems**.** Clients with multiples will need support with infant care, coping, self care and accessing community resources.
Maternal Age: • 17 years of age or younger at the time of post pregnancy screening	• See Post Partum RF matrix • At the time of screening is referring to post partum screening
Tobacco Use • Maternal tobacco use- Currently smokes or uses tobacco. • Second hand smoke exposure of infant- infant is exposed to active smoking in his/her living environment (i.e. inside the home, car, day care	• Any maternal tobacco use including type and amount post pregnancy. • Second hand smoke exposure is focused on anyone actively smoking around the infant in the home or car. • Relapse: If woman quit, but returns to smoking tobacco she can be moved into the B category.
Alcohol and Substance Abuse/Addiction • Stopped substance use upon diagnosis of pregnancy • Used alcohol and substances during pregnancy but a**ctively** engaged in **alcohol/drug treatment** program and has not used for more than or equal to **(≥) 90 days** • **Used** alcohol, illicit substances, or non prescriptive use of prescription drugs **during pregnancy or** a**bstinent** from use of alcohol, illicit substances, or non prescriptive use of prescription drugs for less than **(<) 90 days**	• See prenatal clarification table and post pregnancy risk matrix. • If the woman is incarcerated, time spent incarcerated does not count toward ninety day criteria for abstinence.
Mental Health • **No history** of mental health diagnosis, but answers "Yes" to "In the last month, have you felt down, depressed or hopeless?" or showing potential symptoms of depression, but has **negative** score on standardized depression **screening** tool. i.e. Edinburgh, CES-D • **History of mental health** treatment but is stable, or history of postpartum depression with previous pregnancy, and **negative score** on standardized depression **screening** tool. • **Current mental health** diagnosis and is **engaged** in a mental health treatment • Mental health symptoms are evidenced by **positive score** on standardized	• See prenatal clarification table and post pregnancy risk matrix • If client falls into "A" criteria- providers should re-screen for mood disorder if possible and educate client and support person on signs and symptoms of post partum mood disorders and resources available. • A person actively engaged in treatment may continue to have mental health symptoms and MSS provider shall obtain release of information from client to exchange information with the mental health provider and coordinate care.

depression **screening** tool • Client has a **mental health diagnosis** and **exhibiting active symptoms** which are interfering with general functioning.	
Severe Developmental Disability • Severe developmental disability which could impact the woman's ability to take care of herself during the pregnancy or a child, but **adequate** support system, and **follows through** with health care appts/advice and infant or self care. • Severe developmental disability which impacts the woman's ability to take care for herself during the pregnancy or a child and **inadequate** support system or **does not demonstrate** evidence of follow through with health care appts/advice and infant or self care.	• See prenatal clarification table and post pregnancy risk matrix. • Women who did well during pregnancy may have less support or more issues post pregnancy and should be reassessed.
Intimate Partner Violence • In the last year, the woman's intimate partner or father of baby (FOB) has committed or threatened physical/sexual violence against her.	• See post pregnancy RF matrix • This risk factor focuses on the woman as the person at risk of violence • Infants can be hurt directly and indirectly even when the abuser is not trying to harm the infant**.** For example, an infant is hurt when the abuser strikes the mother who is holding the infant. Other ways IPV impacts the infant is stress in the home that can cause slow weight gain, failure to thrive and other issues in the infant.
Child Protective Services (CPS) • History of Child Protective Services involvement as the parent/caretaker, not current open/active case. • Client is identified as a caretaker within a family unit that has an open CPS	• **CPS =** Child Protective Services, is within the Children's Administration Division of Family Services in the State of Washington or an equivalent service in another state. http://www.dshs.wa.gov/ca/safety/abuseWhat.asp?2 • History must be as a parent or caretaker, clients with CPS involvement where they were the child in need of protection or services do not screen in under this category
Infant • **LBW infant** (less than 5lb 8 oz) • **Preterm infant** (born less than 37 weeks gestation)	• **LBW & Preterm birth infants:** There are multiple potential long term risks for the low birth weight/ preterm infant. There are immediate potential risks in the first 28 days after delivery including: o Respiratory distress o Feeding issues

• **Slow weight gain**- i.e. loss of more than 10% of body weight since birth, has not gained back to birth weight by two weeks of age	o Maintaining body temperature o Infection • **Slow weight gain:** This should be determined by a medical provider or clinician who is trained in child growth. Below are some examples o Loss of more than 7% of body weight since birth, o Has not gained back to birth weight by two weeks of age. o Deceleration of growth passed 2 percentiles. o Growth remains below 5th percentile
Infant Risk Cont • **Breastfeeding complication-** Inadequate transfer of milk/ ineffective suck or inadequate stooling	• **Breastfeeding Complications:** o This risk criteria must be determined by staff trained in breastfeeding assessment- medical provider, IBCLC, lactation consultant o This risk criterion is not referring to breastfeeding moms who just need help with latch but to infants who are showing inadequate milk transfer. o This risk factor can stand alone from the other MSS risk factors or be in addition/result of one of the other MSS risk factors- preterm birth, LBW, or birth defect and/or health issue (cleft palate, cardiac issues etc). o Documentation must support the determination of inadequate milk transfer/ineffective suck. For example inadequate milk transfer as noted by ➢ Test weighing of pre and post feeding indicates minimal intake and ➢ Hypo or hypertonicity o **Inadequate stooling/bowel movements**-. Infant who are not stooling properly can be a sign of inadequate milk transfer and/or hind milk issues. Frequency is an issue and if exclusively breastfeeding stool color is also an issue per AAP- ➢ Meconium (tarry black) 24 hours ➢ Transitional stools (black transitioning to green, then brown and yellow) up to first 4 days ➢ 3 to 4 days: 3 to 4 stools per day ➢ 5 to 7 days- 3 to 6 stools per day, yellow seedy stools
• Infant with **birth defect and health problems** • **Drug/alcohol exposed** newborn per definition on matrix	• **Birth Defects and/or Health Problems**: This can be a long list and should be clearly documented a need for MSS interventions. This risk factor is referring to significant health problems needing medical follow up, case management and MSS intervention by a clinician. There is increased risk of maternal/parental depression when an infant has health issues.

	• **Drug/Alcohol exposed infant**: Infant exposed to drugs and alcohol during pregnancy. See definition in post pregnancy risk matrix for drug exposed. Infants withdrawing or affected by legitimate use of prescription drugs my mother during pregnancy such as methadone would screen in under infant health problems.